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Nos. 02-1845 and 03-83

IN THE
SUPREME COURT OF THE UNITED STATES

AETNA HEALTH INC.
Petitioner,

v.

JUAN DAVILA,
Respondent

CIGNA HEALTHCARE OF TEXAS, INC.
Petitioner,

v.

RUBY R. CALAD, ET AL.,
Respondent

On Writs of Certiorari To The United States Court of Appeals For the Fifth Circuit

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BRIEF *AMICI CURIAE* OF AARP AND THE NATIONAL PARTNERSHIP FOR WOMEN AND FAMILIES IN SUPPORT OF RESPONDENTS

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF *AMICI CURIAE* OF AARP IN SUPPORT OF PETITIONERS

BRIEF *AMICI CURIAE* OF AARP AND THE NATIONAL PARTNERSHIP FOR WOMEN AND FAMILIES

INTEREST OF *AMICI CURIAE*[1/]

AARP is a nonpartisan, nonprofit membership organization of over 35 million persons, age 50 or older, dedicated to addressing the needs and interests of older

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[1/] No counsel for any party authored any portion of this brief. No persons other than *amici curiae*, their members, or their counsel have made a monetary contribution to the preparation and submission of this brief. Petitioners and Respondents have consented to the filing of amicus briefs in support of either party and that consent has been filed with the Clerk of the Court.

Americans. AARP seeks through education, advocacy and service to enhance the quality of life for all by promoting independence, dignity, and purpose. In its efforts to promote independence, AARP works to foster the health and economic security of individuals as they age by attempting to ensure the availability of quality and economical health coverage. As the country's largest membership organization, AARP has a long history of advocating for access to affordable health care and for controlling costs without compromising quality.

As additional means to foster the economic security of older individuals, AARP seeks to increase the availability, security, equity, and adequacy of public and private pension, health, disability, and other employee benefits. Many employed and retired AARP members participate in health care plans sponsored by their employers. Participants and beneficiaries in private, employer-sponsored employee benefit plans rely on the Employee Retirement Income Security Act (ERISA) to protect their rights under those plans. 29 U.S.C. § 1001 *et seq.* However, ERISA, the statute that was designed to safeguard employee benefits, has been applied by many courts to deprive employees of rights and protections they would otherwise have under state health care and insurance laws simply because an employer sponsored health plan paid for their health care.[2/] Thus, as part of its advocacy efforts to ensure, to the greatest extent possible, that participants and beneficiaries receive the benefits of ERISA's protections, AARP has participated as *amicus curiae* in numerous cases involving ERISA's preemption clause, and also filed an *amicus* brief in *Pegram v. Herdrich*, 530 U.S. 211 (2000)(whether claims that a health maintenance organization (HMO) limited care to save money and increase physician compensation could constitute a breach of ERISA's fiduciary duties).

The National Partnership for Women & Families is a national non-profit organization working to improve the lives

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[2/] Patricia Butler & Karl Polzer, Nat. Health Policy Forum, *Private Sector Health Coverage: Variation in consumer protections under ERISA and State Law* (1996).

of women and families through public advocacy, public education, and private partnerships. Founded in 1971 as the Women's Legal Defense Fund, the National Partnership promotes equal opportunity for women, access to quality health care and policies that help women and men meet the competing demands of work and family. The National Partnership has a longstanding history of defending the interests of women in the workplace and working to ensure that women have access to the benefits they need to support themselves and their families. The National Partnership firmly believes that strong and enforceable patient protections are an essential component of ensuring access to quality health care. In support of this goal, the National Partnership has been a leading voice in promoting and defending meaningful patient protections for individuals in employer-sponsored health plans and public health programs.

SUMMARY OF ARGUMENT

ERISA does not preempt state law claims for damages allegedly caused by managed health care organizations' failure to exercise ordinary care in making medical decisions. The claims in both these cases arise out of the managed care entities exercising medical judgment. States have the power to regulate relationships between managed care entities and their enrollees, just as they do all other health care relationships, in order to protect the health and well being of the States' residents, to hold those that benefit from providing health care accountable for injuries they cause, and to provide a mechanism to compensate those who are injured. Holding managed care entities responsible will not undermine employer based health care coverage, or make health care inaccessible. Instead, permitting state courts to determine liability for negligent medical judgment will maintain the balance of equities between managed health care entities and patients, as well as maintain the balance of federalism between federal and state laws. For all of these reasons, the Court should affirm the Fifth Circuit's decision that ERISA does not preempt the plaintiffs' claims under the Texas Health Care Liability Act (THCLA).

ARGUMENT

I. ERISA DOES NOT PREEMPT STATE LAWS REGULATING THE FAILURE TO EXERCISE ORDINARY CARE IN MAKING MEDICAL JUDGMENTS

A. The Proceedings Below

The plaintiffs in these consolidated cases filed claims in state court under the state law known as the THCLA.[3/] The THCLA merely codifies the long standing ability of Texas, as in other States, to protect the health and well being of its residents by establishing that those who exercise medical judgment affecting another person owe a duty of ordinary care to that person. *See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., (Travelers)* 514 U.S. 645, 661 (1995) (health care is an area of traditional state regulation).

Ms. Calad sued her HMO, CIGNA, in state court under THCLA after sustaining personal injuries following a hysterectomy. She alleged that CIGNA failed to exercise ordinary care when CIGNA's hospital discharge nurse determined that Ms. Calad should be discharged after a one day

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[3/] The statute provides:

> A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.

Tex. Civ. Prac. & Rem. Code Ann. § 88.002(a). The THCLA defines "health care treatment decision" as:

> a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees.

§ 88.001(5).

hospital stay although her doctor recommended a longer period. *Roark v. Humana, Inc.* 307 F.3d 298, 302 (5th Cir. 2002). Similarly, Mr. Davila brought suit in state court against his HMO, Aetna, under the THCLA alleging that his bleeding ulcers and near death resulted from Aetna's requirement that Mr. Davila use a different medication than the physician prescribed. *Id.* at 303. Both plaintiffs alleged that their respective HMOs failed to exercise ordinary care in making medical necessity decisions which proximately caused their injuries, and sought compensatory damages. (Joint Appendix, JA-188, Calad Complaint; Aetna Petitioners Appendix, 70A, Davila Complaint.)

CIGNA and Aetna each removed these actions to the United State District Court for the Northern District of Texas, arguing that they were completely preempted under ERISA section 502(a) because plaintiffs' claims were, in essence, merely claims for wrongful denial of benefits from their employer sponsored health insurance. *Roark,* 307 F.3d at 302-303. The district court denied plaintiffs' motions to remand and ordered that the claims be dismissed under Fed. R. Civ. P. 12(b)(6) based upon Section 502 of ERISA. *Id.* at 305. In the consolidated appeal, the Fifth Circuit stated "[b]ecause we conclude that § 502(a) does not displace Calad's or Davila's claims, the district court should have remanded." *Id.*

The Fifth Circuit's analysis of these cases turns on its interpretation of *Pegram v. Herdrich*, 530 U.S. 211 (2000) that mixed eligibility and treatment decisions made by HMOs are not preempted. The Fifth Circuit held that because the HMOs' decisions which plaintiffs challenge here are mixed eligibility and treatment decisions, plaintiffs' claims are not encompassed by § 502(a)(2), and there is no preemption under that provision. *Roark,* 307 F.3d at 308. The Fifth Circuit also determined that ERISA § 502(a)(1)(B), which establishes a federal cause of action for a claim for benefits under a plan, does not preempt the plaintiffs' THCLA claims. *Id.* The court reasoned that plaintiffs are not seeking benefits under their employer sponsored health care plan through the THCLA. Instead, they are seeking tort damages for the alleged medical negligence of the HMO in making health care treatment decisions.

Accordingly, their claims under the state statute do not conflict with ERISA's enforcement procedures for obtaining benefits and are not preempted under that provision either. *Id.* at 308-311.

B. Petitioners' Decisions Involved Medical Judgments.

In *Pegram*, the Court unanimously held that "mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA." 530 U.S. at 237. In determining whether the allegations in *Pegram* could constitute a claim under ERISA for breach of fiduciary duty, and thus fell within the kind of claims Congress intended ERISA to cover, the Court examined the facts in that case to determine how the claims should characterized. The opinion recognized that most managed care coverage decisions are mixed decisions involving when-and-how type questions, with no practical way to untangle eligibility from treatment decisions, and that the decisions in *Pegram* were mixed in nature. *Id.* at 228-29. *Pegram* was not a preemption case, but the opinion nevertheless distinguished eligibility decisions, which would be subject to ERISA's fiduciary duties, from treatment decisions, which were not fiduciary in nature and not something Congress contemplated would fall under ERISA regulation. *Id.* at 231 ("We begin with doubt that Congress would ever have thought of a mixed eligibility decision as fiduciary in nature.") The Court implied that mixed decisions would not be preempted because allowing a plaintiff to challenge an HMO's mixed eligibility and treatment decision under ERISA's fiduciary standards would have presented a "puzzling issue of preemption," seeming "to be a prescription for preemption of state malpractice law" which the Court did not countenance. *Id.* at 236.

Because these cases present themselves in the posture of a review of removal petitions, the facts have not been fully developed below. But an examination of the available facts lead AARP and the National Partnership to conclude that these cases present the sorts of mixed decisions which *Pegram* indicated should not preempted because they are not the sort of

decisions which Congress intended to fall within ERISA's purview.

The facts clearly indicate that CIGNA made a mixed medical/eligibility determination in Ms. Calad's case. CIGNA's nurse decided Ms. Calad did not need another night in the hospital. CIGNA, although it disputes the relevance of the issue, acknowledges that the decision to discharge her earlier than her treating physician recommended was a benefits determination which involved the exercise of medical judgment. CIGNA, Brf. at 27.

Aetna asserts its denial was strictly a benefit decision which did not involve a medical decision, and that there was nothing "mixed" about it. Aetna Brf. at 15. The record suggests otherwise. The facts in the record surrounding Aetna's denial of Vioxx for Mr. Davila which would have been before the lower courts are contained in the Davila Complaint and its attachments reproduced in Aetna Petitioner's Appendix (Pet. App.), at 64a-81a. The Complaint states that coverage for Vioxx was refused despite Dr. Lopez's protests. (Pet. App. 68a.) Dr. Lopez's affidavit attached to the Complaint states that he contacted Aetna after Aetna refused "to fill the prescription." (Pet. App. 77a.) Dr. Lopez also stated that "[r]educing the likelihood of gastrointestinal toxicity was one of my chief concerns I had with respect to prescribing Vioxx for Mr. Davila." *Id.*

Without citation to the record, Aetna asserts that Dr. Lopez did not represent to Aetna that Mr. Davila had a contraindication, intolerance or allergy to the other drugs on Aetna's formulary. (Aetna Brf. at 9.) These would be the conditions precedent for Vioxx to be covered without a trial of two other drugs on the formulary. (Pet. App. 80a.) The record does not indicate if Aetna's decision maker asked Dr. Lopez whether the other drugs were contraindicated or not. But Aetna unequivocally sent a letter to Dr. Lopez stating that "based on the review of information submitted to us, your request to authorize payment for the Formulary excluded medication has been denied." *(Id.)* This demonstrates that Aetna was weighing whether there was sufficient medical evidence to

demonstrate Vioxx was medically necessary in Mr. Davila's case, or whether the other drugs on its formulary were as likely to be equally effective, and therefore, Vioxx was not medically necessary. There may be a factual question over what information was exchanged between the treating physician and the decision maker at Aetna, but from the facts we have in the record, it can be determined that Aetna's denial was based, at least in part, upon its decision of a medical question.

C. Where Medical Judgment Is Used To Determine Eligibility For ERISA Covered Benefits, Liability Claims for Personal Injuries Resulting From that Judgment Should Go Forward in State Court.

These cases present an extension of the question facing the Court in *Pegram*. In *Pegram*, the question was whether Congress meant for challenges to managed health care decisions blending medical judgment and eligibility determinations to come within ERISA's fiduciary obligations and provide for federal jurisdiction. Determining the answer to be no, the Court held the challenge did not state an ERISA claim. *Pegram*, 530 U.S. at 237. In these cases, the question is whether Congress intended federal jurisdiction under ERISA over these mixed decisions to be so complete that it meant to deprive states of their jurisdiction to regulate them – even where ERISA does not provide redress for a similar claim.

Congressional purpose is the ultimate touchstone of preemption analysis. *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992). This Court has stated that the historic police powers of the States are not to be superseded by federal law unless Congress' intent to do so is clear. *Travelers*, 514 U.S. at 655 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). Under the THCLA, the State of Texas is regulating in an area of traditional state concern – liability for medical negligence -- thereby raising the presumption against preemption. To overcome that presumption, Petitioners would have to show that in enacting ERISA, Congress clearly meant to strip States of their historic function of regulating health care. This seems improbable because Congress' primary purpose behind enactment of ERISA was to ensure that

employees received the retirement pension benefits to which they were entitled; health plans were not the focus of Congress' concern. ABA Section of Labor and Employment Law, EMPLOYEE BENEFITS LAW lxviii-lxix (2d ed. 2000). ERISA's declared principal purpose is "to protect plan participants and beneficiaries." *Boggs v. Boggs*, 520 U.S. 833, 845 (1997)(citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983)); ERISA § 2(b), 29 U.S.C. § 1001(b).

Among the ways participants and beneficiaries were to be protected was by ERISA providing for "appropriate remedies, sanctions, and ready access to the Federal courts." ERISA § 2(b), 29 U.S.C. § 1001(b). While Congress was considering what were appropriate remedies for wrongful denial of employee benefits, if it intended to take the draconian step of prohibiting state liability for health plans' medical negligence, surely it would have said so directly. Allowing state law liability for personal injury caused by a HMO's negligent medical decision in addition to providing federal remedies for benefit determinations does not interfere with the goal of protecting participants and beneficiaries. Therefore, it is unlikely that Congress would have considered it necessary to usurp state court jurisdiction on this issue.

The Court in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987) held that ERISA prohibits any remedy for benefits in addition to those specifically enumerated in ERISA's civil enforcement provisions under § 502(a). Here respondents are not seeking plan benefits and so are not seeking additional remedies to obtain those benefits. A finding of liability under THCLA would not result in an award of the benefits, so it does not provide an alternative enforcement mechanism. *Travelers*, 514 U.S. at 657-60; *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002); *Blue Cross of California v. Anesthesia Care Assocs. Med. Group, Inc.*, 187 F.3d 1045 (9th Cir. 1999); *Custer v. Sweeney*, 89 F.3d 1156 (4th Cir. 1996).

A number of Circuit Courts have found that ERISA does not completely preempt state tort claims for violation of state privacy and other rights simply because the alleged conduct arose from the investigation of an employee's eligibility for

benefits. *See Dishman v. UNUM Life Ins. Co. of Am.*, 250 F.3d 1272, *reh'g en banc denied*, 269 F.3d 974 (9th Cir. 2001) (ERISA does not preempt a state tort claim alleging that health insurer's private investigators violated claimant's privacy rights when investigating claimant for claim fraud). *Accord*, *Darcangelo v. Verizon Communications Inc.*, 292 F.3d 181 (4th Cir. 2002) (no preemption of state claims for invasion of privacy, negligence, unfair and deceptive trade practices and medical privacy violations where complaint alleges wrongful conduct on the part of employer and plan administrator unrelated to their duties under the plan); *Trustees of the AFTRA Health Fund v. Biondi*, 303 F.3d 765 (7th Cir. 2002) (no preemption of common law fraud claims against participant who failed to inform the fund that he had divorced his wife in order to maintain her as an insured dependent in the plan so she could receive benefits). The claims of Davila and Calad are no different. They make claims separate and different from merely a claim for benefits.

Not every mixed eligibility and treatment claim will provide a state cause of action. If participants complain about the failure to receive benefits, and seek those benefits as opposed to seeking damages based upon a claim that a negligent medical necessity determination resulted in their injury, then the participants will have to sue under ERISA for failure to receive their benefits. *Cf. Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) (even where independent review finds HMO's denial based on medical necessity was wrong, participant still must sue under ERISA to receive benefit). But where the claim is that the HMO did not exercise care in making the medical judgment, state law should survive preemption under the logic of *Pegram*, 530 U.S. at 237 (refusal to federalize medical malpractice suits).

Thus, in *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003), *petition for cert. filed, sub nom. Vytra Healthcare v. Cicio*, 72 U.S.L.W. 3093 (U.S. Jul. 11, 2003)(No. 03-69), where medical judgment was exercised in the denial of health benefits as demonstrated by the exchange between the treating physician and the HMO's medical director, the Second Circuit found no preemption. In that case, Mr. Cicio was diagnosed with multiple myeloma. His

treating physician asked for approval to treat Mr. Cicio with "high dose chemotherapy supported with peripheral blood stem cell transplantation, in a tandem double transplant, for a diagnosis of multiple myeloma." *Cicio*, 321 F.3d at 87. This request was denied by the HMO. There then ensued a exchange of letters between the doctors, resulting in approval of "a single stem cell transplant", but still denying "tandem stem cell transplant." *Id.* at 88. There was no question that Mr. Cicio needed treatment for his cancer or that he was eligible for treatment. The exchange between the doctors indicated the discussion was over which was the appropriate treatment for his cancer – single stem or double stem transplant. The Second Circuit, applying *Pegram*, held that an HMO medical director's decision denying an HMO participant one form of treatment as experimental and approving another was both a medical treatment decision and a contract interpretation decision, and that the state medical malpractice claim was therefore not preempted because it was based upon a mixed eligibility and treatment decision.

Although ERISA's § 514 "relates to" conflict preemption analysis is not controlling here because removal was based upon complete preemption under § 502, that analysis also supports Respondents' position. The Court has maintained Congress intended to preempt only state laws which refer to or have a significant connection with an ERISA plan. In *Travelers*, the Court recognized that three types of state laws will always be preempted: (1) state laws that mandate employee benefit structures or their administration; (2) state laws that bind employers or plan administrators to particular choices or preclude uniform administrative practice, thereby functioning as regulations of ERISA plans themselves; and (3) state laws providing alternate enforcement mechanisms for employees to obtain ERISA plan benefits. 514 U.S. at 645. These types of state laws are certainly within the field that Congress intended to occupy when it enacted ERISA and will always have a connection to an ERISA plan. *See id.* at 657-60. The THCLA does not mandate the distribution, payment or receipt of benefits. The THCLA does not mandate benefit structures or their administration because it does not address who will receive benefits, the kind of benefits to be paid, or

how those benefits will be paid. Nor does THCLA even purport to provide an additional means of getting plan benefits. *Compare Egelhoff v. Egelhoff ex rel Breiner*, 532 U.S. 141 (2001); *Boggs*, 520 U.S. 833 (1997); *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985). The THCLA does not bind the employer or the plan administrator to any particular choice concerning benefits or administrative practices. Instead it is limited to providing for a claim of liability against a medical entity which fails to exercise ordinary care in making medical necessity decisions, an area of traditional state concern, which this Court has recognized is not preempted. *See Travelers*, 514 U.S. at 654-55, 661; *Pegram*, 530 U.S. at 237. The Fifth Circuit's decision that the cases should have been remanded to state court should be affirmed.

II. HOLDING HMOS RESPONSIBLE FOR CAUSING PERSONAL INJURIES WILL NOT JEOPARDIZE EMPLOYER BASED HEALTH CARE COVERAGE.

A. Permitting Liability for Failure to Exercise Appropriate Medical Judgment Will Not Be Prohibitively Expensive or Reduce Access to Health Care

CIGNA posits that "it can hardly be disputed that imposing . . . medical malpractice . . . on employee health benefit coverage decisions will vastly increase the costs of providing benefits, all but guaranteeing that less coverage and thus less health care overall – will be provided to the nation's employees and union members." CIGNA Brf. at 48. Petitioners' *amici* argue that permitting state suits will cause plan sponsors to restrict benefits, increase employee cost sharing, replace "discretionary decisions with categorical exclusions," or "discontinue, or decline to institute health benefits." *Amicus* brief of AAHP-HIAA, *et al.*, at 5. These dire predictions are overstated.

The direct costs of medical malpractice, measured by insurance premiums paid by physicians, hospitals, HMOs, and other providers, account for less than 1 percent of national

health care expenditures. U.S. Congress, Office of the Technology Assessment, *Impact of Legal Reforms on Medical Malpractice Costs,* OTA-BP-H-1 19 (Washington, DC: U.S. Government Printing Office, October 1993), at 5 (OTA). OTA was reporting on data from the early 1990s, but these costs have been consistent over time, even declining in the last ten years. Malpractice premiums accounted for six-tenths of one percent of total U.S. Health Care costs in 2000, a decline from nearly one percent in 1988.[4/] For 2001, it was 0.43% of total national health care expenditures.[5/]

Holding managed care entities accountable for the injuries which they proximately cause will not substantially increase the costs of health care, and any rise in employer sponsored premiums as a result would likely be minimal. The Congressional Budget Office (CBO) estimated the rise in premiums for employers sponsored health care if Congress had passed the patient protection legislation, S.872, the Bipartisan Patient Protection Act introduced in June 2001 which included a provision allowing for civil liability. The increase was estimated to be a modest 0.8%.[6/]

[4/] Testimony of Travis Plunkett, Legislative Director Consumer Federation of America, Regarding Medical Malpractice Insurance Rates: Hearings Before the Subcomm. on Health of the House Comm. on Energy and Commerce (July 17, 2002) Exhibit B, *available at* http://www.consumerfed.org/Med_Mal_House_testimony.pdf.

[5/] This is based upon comparing $1.4 trillion in total health care costs in 2001as reported by the Centers for Medicare and Medicaid Services (see, http://www.cms.gov/media/press/release.asp?Counter=935 with A.M. Best figures of approximately $6 billion for medical malpractice premiums.

[6/] Letter from Dan L. Crippen, Director, CBO, to Senator Kennedy, Chairman, Comm. on Health, Education, Labor, and Pensions, United States Senate, Cost Estimate for S. 872, the Bipartisan Patient Protection Act, (June13,2001) *available at* http://www.cbo.gov/showdoc.cfm?index=2874&sequence=0. CBO also estimated current federal legislative proposals to limit tort liability for physician malpractice would " lower health care costs by only about 0.4 percent to 0.5 percent, and the likely effect on health insurance premiums

Moreover, a recent evaluation of medical malpractice insurance premiums and their relationship to what liability insurers actually pay out in losses disputes the notion that increased liabilities have made health care unaffordable.[7] The study found that while insurer payouts for jury awards, settlements and other costs over the last thirty years directly tracked the rate of medical inflation, medical insurance premiums rose and fell in relationship with the state of the economy. The study concluded that insurance companies raised physician's malpractice premium rates not because of an "explosion" in payouts, but because they sought ways "to make up for declining interest rates and market-based investment losses."[8]

Petitioners and their *amici* are incorrect when they argue that allowing health plans and insurers to be liable for medical error would drive up health care costs to the point where it will undermine Congress's goal of encouraging employer based coverage and employers will reflexively stop providing coverage. While there is no doubt that rising health care costs pose threats to the availability of sources of health care coverage, both public and private, liability for medical negligence simply does not drive the availability of health care. For example, while the United States General Accounting Office (GAO) found that malpractice premiums for health care providers were rising, they concluded that those increases "did not affect access to health care on a widespread basis" even in states where they confirmed instances of reported problems.[9]

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would be comparably small." CBO, Limiting Tort Liability for Medical Malpractice, January 8, 2004, at 6.

[7] Americans for Insurance Reform, Medical Malpractice Insurance: Stable Losses/Unstable Rates 2003, November 2003, at 8.

[8] *Id.*

[9] GAO, Highlights of GAO-03-386, Medical Malpractice, Implications of Rising Premiums on Access to Health Care, August 2003.

While insurers have raised the cost for employers to purchase health benefit coverage, employers do not attribute the increase to liability for medical negligence or to other costs associated with liability. Nor are employers drastically cutting health benefits in response to the increases. On average insurers increased premiums for employer based health insurance by 13.9% between 2002 and 2003. The researchers at the Kaiser Family Foundation explain:

> The high rate of premium growth in 2003 appears to have been driven by a combination of rapid inflation in the costs for health care services and insurers efforts to emphasize profitability in their pricing. Premium equivalents for self-insured plans (a proxy estimate for medical claims expenses) grew by a lower amount (12.4%) than premiums for fully insured plans, which increased 15.6% this year. This finding may indicate that part of the rise in health care premiums is due to insurers expanding their underwriting gains.[10/]

Employers reported that the major factors contributing to the increases were higher prescription drug spending and higher hospital costs – with no mention of malpractice insurance or other costs associated with liability. The other factors reported were higher spending for physicians, higher insurance company profits, better medical technology, and an aging population.[11/] And although there have been three consecutive years of double digit premium increases, "many employers say . . . that they will increase contributions and cost sharing next year, but very few say they will reduce eligibility or drop coverage."[12/] Changes in the percentage of employers offering coverage have more to do with conditions in the general

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[10/] Kaiser Family Foundation and Health Research and Educational Trust, (Kaiser) Employer Health Benefits 2003 Summary of Findings, Employer Health Benefits 2003 Annual Survey, at 3, available at www.kff.org.

[11/] Kaiser, Cost of Health Insurance, Secton 1, Employer Health Benefits 2003 Annual Survey, at 29, Exhibit 1.11.

[12/] *supra*, note 10, at 1.

economy than increases in malpractice insurance rates. Kaiser reports "the weakened economy and escalating premiums do not appear to have caused a drop in the percentage of employers offering health insurance coverage from last year, but the percentage of firms offering coverage is lower than its pre-recession high (69%) in 2000. In 2003, 66% of all firms offered" health benefits.[13/]

Aetna argues: "affirmance of the decision below would deal a severe blow to the American economy." Aetna Brf. at 44. It argues that permitting managed care entities to be subject to a state law duty of ordinary care when making health care treatment decisions would "decree an end" to managed care. *Id.* But the American economy has long been used to the notion that parties are liable for causing the injuries of others; it is one of the primary reasons the insurance industry exists.[14/] Managed care is the dominant health care delivery mode, a healthy, profitable business model unlikely to wither because of an increased liability potential.[15/]

[13/] *Id.* at 5.

[14/] It further seems likely that HMOs have already undertaken to insure themselves against such liabilities as at least two Federal Circuits have found ERISA does not preempt state laws regulating medical negligence of managed care entities. *Cicio v. Does*, *supra* at 10; *Dukes v. U.S. Healthcare*, 57 F.3d 350 (3rd Cir. 1994) *cert. denied*, 516 U.S. 1009 (1995); *Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001)(on remand for reconsideration in light of *Pegram v. Herdrich*), cert. denied sub nom, *U.S. Healthcare Systems of Pa., Inc. v. Pa. Hosp. Ins. Co.*, 536 U.S. 938 (2002). Some state courts have found also managed care entities vicariously liable under several different theories. *Jones v. Chicago HMO Ltd. of Ill.*, 730 N.E. 2d 1119, 1128 (Ill. 2000); *McClellan v. Health Maint. Org. of Pa.*, 604 A.2d 1053 (Pa. Super. Ct. 1992); *Decker v. Saini*, No. 88-361768 NH, 1991 WL 277590 at 3-4 (Mich. Cir. Ct. Sept. 1, 1991).

[15/] As of 2001, 93% of employees with employer-sponsored health care received that care through some form of managed care: 48% are in preferred provider organizations (PPOs), 23% are enrolled in health maintenance organizations (HMOs) and 22% are in point of service (POS) plans. Jon R. Gabel, Gail A. Jensen & Samantha Hawkins, *Self-Insurance in Times of*

In testimony before the Senate, the Assistant Secretary of the then named Pension and Welfare Benefits Administration of the Department of Labor, the federal agency responsible for administering ERISA, discussed the cost implications of allowing state law remedies for injuries caused by improper denial of health benefit coverage by ERISA health plans.

> The best evidence regarding cost impact exists in those markets where expanded remedies already exist. There is nothing in these markets to show that these remedies result in larger premium costs. For example, participants in group health plans covering State and local employees are outside ERISA and often have access to full State law remedies for injuries that result from improper delay and denial of benefit claims. Yet insurers and HMOs compete aggressively for State and local group business, and there is no evidence that insurers charge higher prices to these groups because of the greater liability exposure associated with them. Thus, it seems highly unlikely that the availability of additional remedies would force employers to retreat from offering health coverage.

Testimony of Olena Berg, before the Senate Subcommittee on Labor, Health and Human Services, and Education, in May 1998.

Growing and Retreating Managed Care, HEALTH AFF., March/April 2003, at 202. Employer-sponsored health insurance covers "159 million active workers and their dependents as well as sixteen million retirees." *Id.* Approximately half of these employees are covered by self-insured plans not subject to state insurance regulation, but half have been subject to state regulation of their businesses through insurance laws. *Id.* at 203. This Court has recognized dual federal and state regulation of ERISA plans for years, and those plans subject to state insurance regulation have not disappeared. *See, e.g., Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985) (states may mandate benefits in insured ERISA plans).

In short, the ominous pronouncements of those urging preemption remind one of the statement attributed to Mark Twain, "reports of my death have been greatly exaggerated."[16/]

B. States Which Allow Managed Care Liability Have Not Seen an "Explosion" of Litigation.

Ten states have enacted laws creating managed care liability since 1997, with Texas having its statute in place longest. A study of these laws reported that there was little in the way of litigation under these statutes in any of the states, and the authors concluded that this was not principally due to "ERISA preemption, but, rather, to the costs and complexities of suing a health plan, which deter lawyers from including this additional defendant in medical malpractice cases."[17/]

[16/] Many different sources have slightly different versions of the quotation. The following information comes from: Respectfully Quoted: A Dictionary of Quotations Requested from the Congressional Research Service. Suzy Platt, ed. Washington: Library of Congress. p. 76 (1989):

> In 1897, Twain was living in London where a cousin, Dr. Jim Clemens, fell ill. The newspapers, believing Twain was near death, sent reporters to investigate. Twain made his remark when the correspondent for the *Evening Sun* told him his death had been reported in New York, and asked what he should cable in reply. Mark Twain (Samuel L. Clemens), "The Report of My Death," Mark Twain in Eruption, ed. Bernard DeVoto, pp. 252-53 (1940). Albert Bigelow Paine, Mark Twain, vol. 2, chapter 197, p. 1039 (1912), gives a slightly different version of the story, ending, "Just say the report of my death has been grossly exaggerated."
> Often heard "...greatly exaggerated."

[17/] Mark A. Hall and Gail Agrawall, The Impact of State Managed Care Liability Statutes, Health Affairs, September/October 2003, Vo. 22, no. 5, 138, 141. Professors Hall and Agrawal wrote that the primary drivers of concerns about liability were pending large federal class actions brought under RICO and ERISA and large punitive damage awards in a few state cases prior to enactment of the MCO liability statutes. *Id* at 140.

But perhaps most interesting, this study found that the statutes did positively impact health plans' behavior by "focusing more attention on the potential for being sued when personal injury results from managed care restrictions. This heightened attention prompted many health plans to review their managed care practices from a legal risk-management perspective." [18] Most health plans interviewed said that "liability is one of the factors that has caused them to improve their procedures for making coverage determinations."[19] This suggests that liability for managed care entities will effectively reduce personal injuries because HMOs will have better practices, which should actually save the HMOs and ERISA plans money in the long run.

C. Arguments that Costs Will Increase Due to "Defensive" Spending are Unfounded.

CIGNA argues that if this Court decides ERISA does not preempt plaintiffs' state claims, that HMOs will engage in granting "defensive" coverage, authorize unnecessary care and drive up the cost of benefits. CIGNA Brf. at 49. Lamenting the "enormous pressure medical malpractice litigation is imposing on the delivery of health care in this country," CIGNA says "at least five to nine percent of total medical expenditures"can be attributed to physicians' defensive behavior to avoid litigation, citing, Daniel Kessler and Mark McClellan, The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care, 60 Law & Contemp. Probs. 81, 83 (1997). CIGNA Brf. at 48.

Kessler and McClellan were studying if state tort reforms such as caps on damages reduced defensive medical practice. They concluded it did because they saw evidence of slower growth in health care expenditures in the range of from 5 to

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[18] *Id.* at 142.

[19] *Id.*

9%.[20] However, their study does not support Petitioners' point. First of all, the study evaluated limiting liability for physicians, not state law immunity for HMOs. Moreover, in August 2003, the General Accounting Office (GAO) examined the data used in the Kessler and McClellan study and found that because their work was limited to a review of hospital costs for elderly Medicare patients with two types of heart disease, these costs could not be generalized across all services, populations, and health conditions, and the study's analysis was also flawed because it did not fully consider the range of other factors that can influence medical spending.

In fact, the GAO criticized the Department of Health and Human Services (HHS) for using these same Kessler and McClellan figures in its recent reports to estimate total national health care spending on defensive medicine saying these estimates were "not reliable."[21] The GAO determined that while most empirical published studies addressing the issue indicate that physicians do practice some defensive medicine in response to perceived malpractice pressures, it was impossible to use these studies to estimate the extent and cost to the health care system as a whole, given the low response rates and imprecise nature of measurements used.[22]

When the Congressional Budget Office (CBO) replicated and expanded the scope of the Kessler and McCllelan studies to include a broader set of conditions "it found no evidence that restrictions on tort liability reduce medical spending. Moreover, using a different set of data, CBO found no statistically significant difference in per capita health care spending between states with and without limits on malpractice

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[20] Kessler and McClellan, at 83.

[21] GAO, Medical Malpractice Implications of Rising Premiums on Access to Health Care (GAO-03-836, August 2003), at 29. Kessler and McClellan did a follow-up study in 2000 and concluded that when they controlled for managed care penetration, estimated savings fell to about 4 percent. *Id.*

[22] *Id.* at 26.

torts."[23] CBO pointed out that "so-called defensive medicine may be motivated less by liability concerns than by income it generates for physicians or by the positive (albeit small) benefits for patients" and concluded, based on its own research and other studies it reviewed, that any savings from defensive medicine by limiting liability would be very small.[24]

Studies have simply not established that holding HMOs accountable in state courts will significantly drive up health care costs, or conversely, that immunizing HMOs from state law liability will result in substantial health care savings.

III. ALLOWING STATE LAW LIABILITY MEANS INJURED PEOPLE HAVE AN OPPORTUNITY TO OBTAIN REDRESS

Affirming the right of states to ensure that those who exercise medical judgment do so with ordinary care means that as a practical matter, insurers would have to insure themselves against the unlikely event that they would lose malpractice litigation under similar state laws.[25] This is a marginal cost compared to the catastrophic losses any given individual with significant personal injuries could face when those injuries arise from an HMO's negligent treatment decision but the person is deprived of any remedy or redress.

In the end, it comes down to a question of equity. The CBO's recent statement regarding limiting liability for physicians is equally applicable to the question of whether HMOs should be liable for state law damages.

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[23] CBO, Limiting Tort Liability for Medical Malpractice, January 8, 2004, 6-7 (available at ftp://ftp.cbo.gov/49xx/doc4968/01-08-MedicalMalpractice.pdf)

[24] *Id.*, at 6.

[25] Only about 30% of medical malpractice litigation claims result in an insurance payout. *Id.* at 4.

> [T]he evidence available to date does not make a strong case that restricting malpractice liability would have a significant effect, either positive or negative, on economic efficiency. Thus, choices about specific proposals may hinge more on their implications for equity—in particular, on their effects on health care providers, patients injured through malpractice, and users of the health care system in general.

CBO, Limiting Tort Liability for Medical Malpractice, January 8, 2004, at 7. State courts have always balanced these equities and there is no logical reason to strip them of this power just because the health care happened to be paid for primarily by the employer rather than the employee.

CONCLUSION

For the above reasons, *amici* urge the Court to affirm the Fifth Circuit's decision that ERISA does not preempt the THCLA.

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